Speech—Language Pathology License Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
Hearing and Speech Credentialing
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Hearing and Speech Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

(This page intentionally left blank.)

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.

☐ **1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name, first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, date and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3: Previous Certification/License/Registration:**
List all states, including Washington, where certifications/licenses/registrations are or were held. Specifically list all certifications/licenses/registrations granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a sheet of paper.

☐ **4: Agent Registration (Contact Person)**
Pursuant to **RCW 18.35.230**, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business, your attorney or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

☐ **5: Education:**
List in date order all graduate school(s) attended, major, month, and year the degree was granted. Please request official transcripts be sent directly from your college or university to the Department of Health. If you need more space, attach a sheet of paper.

☐ **6: Professional Experience:**
Beginning with current employment, list all activities and account for all periods of time from graduation to the present time. A resume will not substitute for completion of the application. If you need more space, attach a sheet of paper.

☐ **7: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by **WAC 246-12-260**. Course content can be found in **WAC 246-12-270**.

☐ **8: Applicant's Attestation:**
You must sign and date this for us to process the application. Read to ensure you understand this section

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Licensure Requirements:

You may apply for licensure as a speech–language pathologist by completing the following requirements:

- Application and fee;
- Have a master's degree or the equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;

  Official Transcripts: Your transcripts must indicate the degree and date granted. The transcripts must come directly from your college or university to the Department of Health.
- Postgraduate professional work experience;
- Professional reference request form to be completed by your postgraduate supervisor;
- Pass the nationally recognized speech-language pathology examination; **OR** Official verification of the American Speech and Hearing Association (ASHA) Clinical Competency Certifications (CCCs) sent directly from ASHA;
- Four hours of HIV/AIDS education and training; and
- Out-of-State verification form completed by each state(s) where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

Interim Permit Requirements:

You may apply for an interim permit as a speech–language pathologist by completing the following requirements:

- Application and fee;
- Have a master's degree or equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;

  Official Transcripts: Your transcripts must indicate the degree and date conferred. The transcripts must come directly from your college or university to the Department of Health.
- Practice under the supervision of a Washington State licensed speech-language pathologist;
- The Professional Reference Request form is to be completed by your postgraduate supervisor;
- Acknowledgement of Responsibility form to be completed by your supervisor;
- Four hours of HIV/AIDS education and training; and
- Out-of-State verification form to be completed by each state(s) where you hold or

have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

Other Information:

You will be mailed a letter regarding the deficiencies of your application if the application is incomplete.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through a section instead of leaving it blank.
- The initial license will expire on your birthday unless the initial license is issued within 90 days of your next birthday.
- Licenses must be renewed every year on your birthday as provided in Chapter **246-12 WAC, Part 2.** A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the hearing and speech program is available on our **Website**.

Continuing Education Requirements:

Speech-language pathologists must complete a minimum of 30 hours of continuing education every three years.

The required continuing education must be obtained during the period between renewals. For more information on the continuing education requirement, please see **WAC 246-828-510** and **246-12 WAC, Part 7**.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0216020000

Speech–Language Pathologist License Application

Please indicate which you are applying for:

- ☐ Speech–Language Pathologist License
- ☐ Speech–Language Pathologist Endorsement License
- ☐ Speech–Language Pathologist License Interim Permit

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

Address

City | State | Zip | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City | State | Zip | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # _____ Issue Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Previous Certification/License/Registration

List all states, including Washington, where certifications/licenses/registrations are or were held. Specifically list all certifications/licenses/registrations granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate/license/registration is current.

State Jurisdiction	License Number	License		Method of License
		Issue Date	Expiration Date	

An "Out-of-State Verification for Registration/License/Certification" form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

4. Agent Registration (Contact Person)

Pursuant to RCW 18.35.230, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent _____

Address _____

City _____ State _____ Zip _____

5. Education

List in date order all graduate school(s) attended, major, and month and year the degree was granted. A transcript is to be requested from the graduate school(s) and sent directly from the graduate school to the Department of Health, Hearing and Speech Credentialing.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

6. Professional Experience

List all professional experience in date order.

Indicate Type of Experience or Practice and Location	Inclusive Dates of Experience	
	Start (mm/yyyy)	End (mm/yyyy)

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

8. Applicant's Attestation

I,_____, declare under penalty of perjury under the laws of the state of
Name of Applicant

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW **18.130.170** and RCW **18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
mm/dd/yyyy City, State

by: _____
Original Signature of Applicant

(This page intentionally left blank.)

Washington State Department of Health
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Professional Reference Request

To be completed by post-graduate supervisor. Please **type** or **print** Clearly. Please be advised upon receipt of written request, this form will become a public document.

Supervisor	Organization	
Position		
Address		
City	State	Zip

_____, has applied for license as an Audiologist/Speech Language Pathologist in the state of Washington. We would appreciate your completion of this reference form and return directly to the above address.

1. Relationship to Candidate: ☐ Post-Graduate Supervisor ☐ Other (specify) _____

   Appropriate dates of this relationship: From _____ To _____

   Percent of applicant's time spent in audiology/speech pathology work: _____

   Title of applicant's position and name of organization: _____

2. Describe briefly the applicant's duties as you know them in the position listed above: _____

   _____

   _____

   _____

3. Please comment on the applicant's professional judgment, responsibility, integrity and relationships with professional peers and clients: _____

   _____

   _____

4. If you were a supervisor of the applicant's post-graduate work, please complete the following:

   A. Dates of post-graduate supervision: From _____ To _____

   B. Total number of hours of post-graduate audiology/speech pathology work you supervised (this should be a number and not a percentage): _____

   C. Total number of hours of face to face supervision you provided (this should be a number and not a percentage): _____

Applicants are required to have thirty-six weeks of full-time professional experience or part-time equivalent.

5. Please check the areas in which you judge the candidate to be technically competent and able to meet reasonable standards in the profession of audiology/speech pathology. Please double-check what you regard as the applicant's specialty area(s):

☐ Audiology ☐ Speech Language Pathology ☐ Medical ☐ Education ☐ Other _____

Do you feel the candidate is a credit to the profession of audiology/speech pathology?

☐ Yes ☐ No Please explain: _____

6. Do you have any reservations against recommending the applicant for certification in the state of Washington for independent practice? ☐ Yes ☐ No

If Yes, please comment specifically. Include any other information you consider relevant: _____

_____

_____

7. Is there any other information about the candidate which you believe should be provided to the Board of Hearing and Speech? ☐ Yes ☐ No If Yes, please explain: _____

_____

_____

_____

_____

I have carefully read the questions in the professional reference form. I have answered them completely, without Reservations of any kind, and I declare under penalty my answers and all statements made by me herein are true and correct.

Signature _____ Date _____

Your Name (please print)_____ Telephone _____

Highest degree earned _____

Licensed Audiologist ☐ Yes ☐ No State(s) _____ Yr. Cert. _____ Cert #_____

Licensed Speech Path ☐ Yes ☐ No State(s) _____ Yr. Cert. _____ Cert #_____

Seal

Subscribed and Sworn to before me this _____

Day of _____ , 20 _____

Notary Public in and for the _____

State of _____

Residing at _____

Thank you for your cooperation.

Washington State Department of Health
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Acknowledgment of Responsibility for Interim Permit

Speech-Language Pathology Interim Permit
or
Audiology Interim Permit

To the Supervisor:

Please review **RCW 18.35.060** and the Board of Hearing and Speech, Speech-Language Pathology, and Audiology interim permit rule **WAC 246-828-045**.

To supervise a permit holder, you must be licensed in Washington State and in good standing for at least two years unless otherwise approved by the board.

You shall provide supervisory activities as outlined in **WAC 246-828-04503**.

As supervisor, you are responsible for all acts of the interim permit holder in connection with speech-language pathology or audiology services during the postgraduate professional work experience. An audiologist or speech language pathologist licensed under chapter **18.35 RCW** may supervise up to four interim permit holders concurrently.

The supervisor must submit to the department, on a form provided by the department, documentation of supervision and progress during the postgraduate professional work experience, at the end of each three-month period.

Please review supervision delegation as outlined in **WAC 246-828-04505**.

The supervisor of an interim permit holder who desires to terminate the responsibility as supervisor must immediately notify the department in writing of the termination. The supervisor is responsible for the interim permit holder until the notification of the termination is received by the department.

Please complete the following documentation and return to the Department of Health

Acknowledgment of Responsibility—to be completed by Supervisor

I, _____ , a licensed Speech Language Pathologist
Name of Supervisor
or Audiologist in the state of Washington with license number _____ ,

acknowledge that I will take full responsibility for all acts of _____
Name of Interim Permit Holder
in connection with speech-language pathology or audiology services provided while under my supervision.

Signature of Supervisor _____
Date _____

(This page intentionally left blank.)

Washington State Department of Health
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

To Applicant:

Please complete this section. Forward this form to the jurisdiction of certification/license for them to complete and return to the above address.

I,_____, am/was certified/licensed in the state of _____,

as a _____, certificate/license number: _____.
I have applied for a Washington State Speech-Language Pathologist License. I authorize the release of the information requested below to Washington State Hearing and Speech Credentialing.

Signature _____ Date _____

To the State Board:

Please provide **a copy of the current statute** under which the above named applicant was certified/licensed. Please return this completed form with the statute to the above address.

I hereby certify that _____ was granted

professional certificate/license number _____ to practice _____

in the state of _____ on the _____ day of _____ , 20 _____ on the basis of:

	Yes	No
Successfully passing the National Examination in Speech-Language Pathology.	☐	☐
Successfully passing the required state constructed examination.	☐	☐
Written	☐	☐
Practical	☐	☐

Other (please explain):_____

Status of Certification/License: ☐ Active ☐ Inactive ☐ Expiration Date _____

Legal or Disciplinary Action?: ☐ Yes ☐ No If yes, please explain below and provide any applicable documentation. _____

_____

_____

State Seal

Signature of Verifier _____

Title of Verifier _____

Date _____

(This page intentionally left blank.)

Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130
Administrative Procedure Act .....APA RCW 34.05
Administrative procedures and requirements..... WAC 246-12
Hearing and Speech RCW ..... RCW 18.35
Hearing and Speech WAC ..... WAC 246-828

AIDS Courses

Health Impact ..... 1.800.783.2437 **or** 206.284.3865
W.F. Professional.....1.800.323.4305
AIDS Resources.....206.784.5655

On-Line

AIDS Training ..... Reference Page
Board of Hearing and Speech ..... Web Page